

The Norwegian Mother and Child study

Questionnaire 5 – Child aged 18 months

Some of the questions in this questionnaire you may recognize from earlier questionnaires. This is because we want to follow up on your and your child's progress.

To make it easier for you we suggest that you have your child's health card at hand when you fill out this questionnaire. If you think any of the questions are difficult to answer go on to the next question.

A computer will process this questionnaire and it is therefore important that you follow these instructions: -

- Please use a blue or black ballpoint pen
- Put a cross in the box that is most relevant, thus
- Should you put a cross in the wrong box correct it by filling in the box completely, thus
- In the large green boxes write a *number* or a *capital letter*

It is important that you only write in the white area of each box, thus:

- The boxes contain two or more squares. When filling in a single figure, please use the square to the right; e.g. 5 is written like this:
- Specific information e.g. medication or profession should be written in the box on the corresponding line

Please write clearly in CAPITAL LETTERS

Please return the form in the stamped addressed envelope provided.

Date: - Day month year

Question	Answer
Your child - Nutrition	
1. What kind of milk has the baby had since it was 6 months old? <i>(you may fill in more than one)</i>	<i>Milk type / Child's age in months / 6-8, 9-11, 12-14, 15-18</i> 1. Breast milk / 2. Formula / 3. Formula for children with milk allergy/intolerance / 4. Full-cream milk/ 5. Semi-skimmed milk / 6. Extra semi-skimmed milk / 7. Skimmed milk / 8. Biola (Lactobacillus-fermented) (all types) / 9. Other yogurt / 10. Other kinds of curdled milk
2. How often does the baby drink any of the following now at approx. 18 months? <i>(one cross for each line)</i>	<i>Never / less than 1 time a week / 1-3 times a week / 4-6 times a week / 1-2 times in 24 hours / 3-4 times in 24 hours / 5 times or more in 24 hours</i> 1. Breast milk / 2. Formula / 3. Full-cream milk / 4. Semi-Skimmed milk / 5. Extra semi-skimmed milk / 6. Skimmed milk / 7. Biola – all kinds / 8. Other kinds of yogurt / 9. Other kinds of cultured milk / 10. Tap water / 11. Bottled water / 12. Cordial, with sugar / 13. Cordial with artificial sweeteners / 14. Juice / 15. Soda pops / 16. Soda pops with artificial sweeteners / 17. Other
3. Does the baby drink any of the following during the night now at approx. 18 months <i>(one cross for each line)</i>	<i>Never/rarely / Sometimes / yes, most nights</i> 1. Water / 2. Milk or juice from a cup / 3. Milk or juice from a bottle / 4. Breast-fed
4. How often does the baby eat any of the following foods now at approx. 18 months?	<i>Never / less than 1 time a week / 1-3 times a week / 4-6 times a week / 1-2 times in 24 hours / more than 3 times in 24 hours</i> 1. Bread with liver paste / 2. Bread with meat / 2. Bread with fish products / 4. Bread with cheese / 5. Bread with jam/honey / 6. Bread with other spread / 7. Industrial baby cereal / 8. Homemade baby cereal / 9. Meat, sausage, meatballs etc. / 10. Fish, fish balls etc. / 11. Pancakes / 12. Potatoes / 13. Pasta / 14. Rice / 15. Peas, beans / 16. Other boiled vegetables / 17. Raw vegetables / 18. Fruit / 19. Cakes, cookies, waffles / 20. Dessert, ice cream / 21. Chocolate / 22. Sweets
5. Does the baby have home made dinner or commercially produced dinner?	Only home made / Mostly home made / Half of each / Mostly commercially produced / Only commercially produced
6. How often does the baby get ecologically grown food/drink?	<i>Never/ Sometimes/ Often/ Almost always</i> Sweet milk / Cultured milk/yogurt / Vegetables/fruit / Cereals/flour/bread / Meat

7. Does the baby react to certain kinds of food?	<i>Yes / No / Don't know</i>
8. If yes, to what kind of food does the baby react? (<i>you may fill in more than one</i>)	1. Full-cream milk /2.Skimmed/semi-skimmed milk /3.Cream /4. Yogurt/cultured milk / 5. Ice cream / 6. Cheese / 7. Raw egg (e.g. eggnog) /8. Egg, boiled or fried / 9. Fish/fish products /10. Additives / 11. Wheat /12. Nuts /13. Soya /14. Fruit, berries /15. Vegetables/potatoes /16. Chocolate /17. Other sweets /18. Sugar /19. Other:
9. Do you deliberately avoid giving your baby certain kinds of food?	<i>No / Yes</i>
10. If yes, what kinds of food do you try to avoid, and how strict is the diet?	<i>Somewhat reduced use compared to ordinary diet / Not used by itself, but allow small amounts mixed in foods / Avoid all use (incl. "hidden" in other dishes)</i> 1. Milk /2. Egg /3. Fish/fish products /4. Meat/meat products /5. Wheat / 6.Sugar /7. Other:
11. Do you give the baby cod liver oil, vitamins, iron or other nutritional supplements?	<i>No / Yes</i>
12. If yes, state which product(s) and how frequently this is given. How old was the child when you first gave him/her this product?	<i>How often / Daily / Sometimes / How old was the child when you started to give him/her this product? Age in months</i> 1. Cod liver oil /2. Biovit /3. Sanasol /4. Collett infant vitamins /5. Fluoride tablets /6. Iron supplement, what kind /7. Other, what kind
Growth, health and medication	Please have your baby's health card available when filling in the following questions
13. How many times have you taken the child to the well baby clinic?	0-4 / 5-10 / 11-15 / 16 or more
14. Do you want your baby to have vaccinations recommended for children in Norway?	Yes, all vaccinations / Yes, some vaccinations / No, no vaccinations
15. Please mark what kind(s) of vaccination your child has had, and the number of times it has been given. Please also mark side effects, if any, that led to contact with doctor or hospital	<i>No / Yes / If Yes, how many times / 1 / 2 / 3 / Side effect leading to contact with doctor / No / Yes / Side effect leading to examination/hospitalization / No / Yes</i> Vaccinations / 1. DTP (Infanrix) / 2. Hib (Haemophilus influenza type b) /3. Polio – H1b (Act-H1b polio) /4. MMR (measles, mumps, rubella) /5. DT

	(diphtheria/tetanus) /6. Hepatitis B (Engerix.B) /7. BCG (tuberculosis) /8. Other vaccination
16. Does your child have, or has it had, any of the following health problems. If yes, has he/she been referred to a specialist? (Please mark each line)	<p><i>No /Yes, currently / Only in the past /</i> <i>If yes (currently or in the past), has the child been referred to a specialist examination / Yes / No</i></p> <p>Health problem</p> <p>1. Hips /2. Hearing /3. Sight /4. Delayed motor development (e.g., sits, stands, or walks late) / 5. Too slow increase in weight /6. Too fast increase in weight /7. Diverging head circumference /8. Cardiac failure /9. Undescended testes /10. Asthma /11. Atopic (child) eczema /12. Urticaria / 13. Food allergy/intolerance /14. Delayed or aberrant language /15. Sleep problems /16. Behavioral problems/ 17. Contact problems 18. Other malformations: _____ 19. Other: _____</p>
17. If the child was further examined, what did this examination show?	<p><i>Everything was fine / Still questionable/further tests / Has not been examined yet / Has the following diagnosis: _I, II, III,</i></p> <p>_____</p>
18. Has the child been treated with a “pad” for hip disease	No / Yes / How long? / months
19. Has your child had any of the following illnesses/health problems at the age of 6 – 11 months, and/or at the age of 12-18 months. Please also state how many times and whether the child was hospitalized. (Please mark each line)	<p>Illness/health problem / Aged 6-11 months / No / Yes /Number of times/ Aged 12-18 months / No / Yes / number of times / Hospitalized / No / Yes</p> <p>1. Cold /2. Throat infection with proven streptococci /3. Other throat infection / 4. Ear infection /5. Laryngitis /6. Bronchitis/RS-virus/Pneumonia /7. ”Gastric flu”/diarrhea /8. Urinary tract infection /9. Eye infection /10. Fever seizures /11. Other seizures (without fever) /12. Chickenpox /13. Accident or injury /14. Other: _____</p>

20. Has the child seen a doctor or been to hospital at the age of 6-11 months and/or 12-18 months? If yes, please state how many times. <i>(Please mark each line)</i>	<i>At the age of 6-11 months / No / Yes / Number of times / At the age of 12-18 months / No / Yes / Number of times</i> General practitioner (outside the well baby clinic) / Emergency ward doctor / Private specialist / Outpatient at hospital / Hospitalized
21. Has your child been referred to: <i>(Please mark each line)</i>	Child habilitation unit / School psychological services/ Child psychiatry services/ <i>No / Yes</i>
22. If the child has been examined or admitted to hospital, give the name of the hospital	Name of hospital / Name of hospital / Name of hospital
23. Has the child had any of the following symptoms during the last 12 months? If yes, at what age? <i>(Please mark each line)</i>	<i>Had the symptoms? / No / Yes / If yes, at what age / 6-8 months / 9-11 months / 12-14 months / 15 months or more</i> 1. Wheezing /2. Chest tightness /3. Coughing at night /4. Dripping nose without a cold /5. Constipation /6. Diarrhea /7. Recurring itchy skin eruption
24. Has the child been tested for allergy?	No / Yes
25. If yes, for what was he/she tested and was the test positive?	<i>Was the test positive? / No / Yes / Don't know</i> Test: /1. Milk /2. Egg /3. Fish /4. Mold /5. Mite /6. Animals /7. Pollen /8. Other:
26. Have you seen so called alternative medicine practitioners during the last 12 months?	No / Yes /number of times:
27. If yes, what kind of alternative medicine?	
28. Has the child been given medicines (including alternative or herbal products) during the last 12 months?	No / Yes
29. If yes, please state the name of the medicine and the child's age when the medicine was given. <i>(All types of medication including herbal remedies)</i> / Name of medicine <i>(e.g. Apocillin, Paracet)</i>	<i>How old was the child when medicated? / 6-8 months / 9-11 months / 12-14 months / 15-18 months</i>

30. Please fill in the child's length, weight and head circumference at approx. 8 months, 1 year and when last measured (15-18 months).	<i>Date when measured / Day / Month / Year / Weight / Length / Head circumference / Approx. 8 months / Approx. 1 year / 15-18 months / g / g / g / cm / cm / cm / cm / cm</i>
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Development and behavior	
31. How old was the child when he/she took his/her first steps alone?	Number: months Does not yet walk unsupported
32. Below you will find some questions about the child's development at approx. 18 months. (<i>Please mark each line</i>)	<i>Yes / Sometimes / Not yet</i> 1. When you ask him, does your child go into another room to find a familiar toy or object? (e.g. if you ask him/her: "Where is your ball? ", "Go get your jacket" or "Go get your blanket") /2. Does the child say 8 or more words in addition to "mum" and "dad"? / 3. Without showing him first, does your child point to the correct picture when you say for example "Show me the kitty" or "Where is the dog"? / 4. Does the child move around by walking rather than crawling on her hand and knees? / 5. Does your child walk well and seldom fall? /6. Does the child walk down stairs if you hold on to one of his/her hands? / 7. Does your child throw a small ball with a forward arm motion? (If he simply drops the ball, check "not yet" for this item) / 8. Does your child stack a small block or toy (about 1 inch in size) on top of another /9. Does your child turn the pages in a book by himself? (He/she may turn more than one page at a time) /10. Does your child play with a doll or stuffed animal by hugging it? /11. Does your child get your attention or try to show you something by pulling on your hand or clothes? /12. Does your child come to you when he/she needs help, e.g. to open a box? /13. Does the child copy activities you do, such as wipe up a spill, sweep, shave or comb hair?

<p>33. More on the child's development(<i>Please mark each line</i>)</p>	<p><i>Yes usually / Rarely / Not Yet</i></p> <p>1. Does your child use sounds or words <i>together</i> with gestures? (e.g., uses sounds when pointing or reaching towards toys or objects) /2. When you <i>look at</i> a distant object and, surprised and excited, say "Wao...what's that?", does he/she <i>turn</i> his/her head in the <i>same direction</i> as you? /3. When you enthusiastically say "Where is the ball?" <or other toy>, will your child point towards the toy even if it is more than 3 feet away? / 4. Does your child show you toys by looking at you and holding toys up towards you? (from a distance just so you can look at it)</p>
<p>34. How well do the following statements describe your child? (<i>Please mark each line</i>)</p>	<p><i>Very typical / Quite typical / Both-and / Not very typical / Not typical</i></p> <p>1.The child cries easily /2. The child is always on the go /3. The child prefers to play with others rather than by him-/herself /4. The child is off running as soon as he/she wakes up /5. The child is very sociable /6. The child takes a long time to warm up with strangers /7. The child gets upset easily/8. The child prefers quiet, inactive games to more active ones. /9. The child likes to be with people /10. The child reacts intensely when upset /11. The child is very friendly with strangers/12. Prefers certain clothing or complains that certain garments are too tight or scratchy /13. Is distressed by having face or hair washed</p>

35. More on the child's behaviour. Please fill out the following about how your child *usually* is. Please try to answer every question. If the behaviour is rare (e.g., you've seen it once or twice), please answer as if the child does *not* do it.
(Please mark each line)

Yes / No

1. Is your child interested in different sorts of objects, and not for instance mainly in cars or buttons? /2. When your child expresses his/her feelings, for instance by crying or smiling, is that mostly on expected and appropriate moments? /3. Does your child react in a normal way to sensory stimulation, such as coldness, warmth, light, sound, pain or tickling? /4. Can you easily tell from the face of the child how he/she feels? /5. When your child has been left alone for some time, does he/she try to attract your attention, for instance by crying or calling? /6. Is the behaviour of your child without stereotyped repetitive movements like banging his/her head or rocking his/her whole body? / 7. Does your child like to be cuddled? /8. Does your child ever smile at you or at other people? /9. Does your child react when spoken to, for instance, by looking, listening, smiling, speaking or babbling? / 10. Does your child ever try to comfort you when you are sad or when you have hurt yourself? / 11. Has your child had things that he/she seemed to have to do in a particular way or order, rituals that he/she has to have you do? / 12. Does your child ever do things to make you laugh?

36. Please fill out the following about how your child *usually* is. Please try to answer every question. If the behaviour is rare (e.g., you've seen it once or twice), please answer as if the child does *not* do it.
(Please mark each line)

Yes / No

1. Does your child enjoy being swung, bounced on your knee, etc.? / 2. Does your child take interest in other children? / 3. Does your child like climbing on things, such as up stairs? / 4. Does your child enjoy playing peek-a-boo/hide-and-seek? / 5. Does your child ever pretend, for example, to talk on the phone or take care of dolls, or pretend other things? / 6. Does your child ever use his/her finger to point, to ask for something? / 7. Does your child ever use his/her index finger to point, to indicate interest in something? / 8. Can your child play with toys in varied ways (not just fiddling, mouthing or dropping them) / 9. Does your child ever bring objects over to you to show you something? / 10 Does your child look you in the eye for more than one second or two? / 11. Does your child ever seem oversensitive to noise? (e.g. plugging ears) / 12. Does your child smile in response to your face or your smile? / 13. Does your child imitate you? E.g. you make a face – will your child imitate it?) 14. Does your child respond to his/her name when you call? / 15. If you point to a toy across the room, does your child look at it? / 16. Does your child look at things you are looking at? / 17. Does your child make unusual finger movements near his/her face? / 18. Does your child try to attract your attention to his/her own activity? / 19. Have you ever wondered if your child is deaf? 20. Does your child understand what people say? / 21. Does your child sometimes stare at nothing or wander with no purpose? / 22. Does your child look at your face to check your reaction when faced with something unfamiliar?

37. Here is a list of items that describes children. For each item that describes the child <i>now or within the past 2 months</i> , please answer all items as well as you can, even if some do not seem to apply to the child.	<i>Not true / Somewhat or Sometimes True / Very True or Often True</i> 1. Can't concentrate, can't pay attention for long /2. Quickly shifts from one activity to another /3. Can't sit still, restless, or hyperactive /4. Gets into everything /5. The child is mostly happy and well behaved / 6. Clings to adults or too dependent /7. Gets too upset when separated from parents / 8. Gets in many fights / 9. Hits others /10 Defiant. /11. Doesn't seem to feel guilty after misbehaving /12. Punishment doesn't change his/her behaviour /13. Doesn't eat well / 14. Likes almost any food /15. Resists going to bed at night /16. Doesn't want to sleep alone /17. Afraid to try new things / 18. Disturbed by any change in routine /19. Too fearful or anxious
38. How often does the child wake up during the night?	<i>3 or more times a night / 1-2 times a night / Sometimes during the week / Seldom or never</i>
39. How many hours does the child sleep altogether during a 24-hour period?	<i>10 hours or less / 11-12 hours / 13-14 hours / 15 hours or more</i>
40. Worries	<i>No/ Yes / Don't know</i> Are you worried about your child's physical development? /2. Are you worried about your child's behavior? /3. Are you worried because your child is difficult to handle? /4. Are you worried because your child shows very little interest in playing with other children / 5. Do you have other worries about your child's health? What:_____

Your child's everyday life	
41. Where is the child looked after during daytime? Please mark for each age (<i>Cross for each line</i>)	<i>Home with mother/father / Home with baby minder/au pair / At baby minder's home /Family day care / Kindergarten</i> 1. 0-6 months /2. 7-9 months /3. 10-12 months /4. 13-15 months /5. 16-18 months
42. How many hours are spent per day in present day care arrangement (other than with mother and father)?	hours

43. How many children spend their day together with your child (if day-care center, how many children in the group?)	children
44. Do you and the child live together with the child's father?	<i>Yes / no</i>
45. If your child does not live with his/her father, how much time do the two of them spend together?	<i>At least half the time / At least once a week / At least once a month / More rarely than once a month / Never</i>
46. How many times have you moved since the baby was born?	times
47. How large is your present flat/house?	m ²
48. Do you have electrical heating in cables under the floor in any room where the child is?	<i>No / Yes</i>
49. If yes, in which rooms? (<i>You may fill in more than one</i>)	<i>Living room / Kitchen / Nursery/ Bedroom / Hall / Bathroom / Other rooms</i>
50. Has your house been damaged by wet rot, has there been any visible mold or mold smell during the last year? (<i>You may fill in more than one</i>)	<i>No / Yes, wet rot / Yes, visible mold / Yes, mold smell</i>
51. What kind of drinking water do you have?	<i>Water from public or private water works / Water from private source (e.g. well water) / Don't know</i>
52. Is your house situated close to a pylon?	<i>No / Yes, closer than 50 meters / Yes, 50-100 meters away / Yes, but more than 100 meters away</i>
53. Are there any animals in the child's home/at the day care?	No / Yes, at home /Yes, at the day care
54. If yes, what kind of animal? (<i>You may fill in more than one</i>)	Dog / Cat /Guinea pig, hamster, mouse, rat, etc. / Budgerigar other caged bird / Other animal:
55. Is there any smoking in the room(s) where your child spends his/her day?	<i>Yes, daily / Number of hours per day / Yes, several times per week / Yes, once in a while / Not sure / No</i>
56. How often do you brush your child's teeth?	<i>Twice a day or more often / Once a day / Sometimes / Never</i>
57. Do you brush with fluoride toothpaste?	<i>No / Sometimes / Yes, usually</i>

58. How much time does the child spend outdoors these days?	<i>Rarely any / Often, but less than one hour per day / 1-3 hours per day / More than 3 hours per day</i>
59. How many hours daily - on average - does the child spend in front of the television/video?	<i>4 hours / 3 hours / 1-2 hours / Less than 1 hour / Rarely/Never</i>
60. Does the child go, or has he/she been, to baby swimming?	<i>No / Yes / If yes, for how long? months</i>
61. Does the child use a pacifier now at the age of 18 months?	<i>Rarely or never / Only when he/she is going to sleep / Quite often / Most of the time</i>
About yourself	
Health and use of medication	
62. How is your marital status at the moment?	<i>Married / Live-in boyfriend / Single / Separated/divorced / Widow / Other</i>
63. Are you pregnant at the moment?	<i>No / Yes / If yes, how many weeks?</i>
64. Are you suffering from a long lasting illness that started during the last 12 months?	<i>No / Yes, which?</i>
65. Have you yourself been hospitalized during the last 12 months?	<i>No / Yes, which hospital?</i>
66. Do you use cod liver oil, vitamins or any other dietary supplements?	<i>No / Yes, what product?</i>
67. What is your weight these days?	<i>_____kg</i>
68. Has any of the following happened during the last 6 months – or any time in life? <i>(Please mark each line)</i>	<i>Last 6 months / Yes / Maybe / No / Earlier/ Yes / Maybe / No</i> 1. You found yourself overweight? /2. You were very concerned not to gain weight or to be fat /3. Others said you were too thin, but yourself, you felt too fat /4. You felt it most important for your self esteem to keep a certain weight

69. Has any of the following happened during the last 6 months – or any time in life? – And if so, how often did it happen? <i>(Please mark each line)</i>	<i>Last 6 months / At least 2 times a week / 1-4 times a month/ rarely/never Earlier / At least 2 times a week / 1-4 times a month/ rarely/never</i> 1. You lost control while eating, and could not stop until you had eaten far too much /2. You vomited in order to control your weight gain /3. You used laxatives in order to control your weight gain /4. You used fasting in order to control your weight gain /5. You used hard physical exercise in order to control your weight gain
70. During the last 6 months, or earlier in life, have you ever experienced a period of at least 3 months without your period (without being pregnant or in a period with childbirth/breastfeed) in connection with eating disorders?	<i>No, never / Yes, in the last 6 months / Yes, earlier</i>
71. During the last 12 months, have you felt pain in any of the following places? <i>(Please mark each line)</i>	<i>Seldom/never / Mild pain / Some pain /Severe pain</i> 1. Stomach /2. Arms/legs /3. Neck/shoulders /4. Head /5. Back /6. Pelvic pain
72. If you have felt back or pelvic pain during the last 12 months, mark the degree of pain for each place:	<i>Some pain /Severe pain</i> 1. In the lower back /2. In one of the pelvic-sacral joints /2. In both pelvic-sacral joints /4. In the coccyx (tailbone) /5. In the buttocks /6. In the pubic area /7. In the groin /8. Other back pain /9. Other pain
73. Do you, at present, wake up at night because of pelvic pain?	<i>No, never / Yes, occasionally / Yes, frequently</i>
74. Do you, at present, have so much pelvic pain that you have to use crutches or a stick?	<i>No, never / Yes, but not daily- the pain varies from day to day / Yes, daily</i>
75. Have you had treatment for pelvic pain after your last birth?	<i>No / Yes</i>
76. If yes, what kind of treatment? <i>(You may fill in more than one)</i>	Physiotherapy / Chiropractor / Medication / Other:
77. Have you, at present, any of the following problems? <i>(fill out each line)</i>	Problems: 1.Urine leakage when you cough, sneeze or laugh /2. Urine leakage during physical activity (running jumping) /3. Sudden need to urinate (difficulty in reaching the bathroom in time) /4. Problems with stool leakage /5. Problems with passing gas <i>How often have you had problems? / Never / 1-4 times a month / 1-6 times a week/ Once a day/ More than once a day/ How much at a time? Drops/ Large amounts</i>

78. Do you use medicines regularly?	<i>No / Yes</i>
79. If yes, give name of medicine and how often you take it. (<i>All types of medication including herbal remedies</i>)	Name of medicine (<i>e.g. Apocillin, Paracet</i>) How often do you take it? / Every day / Daily for intervals / Now and then
Economy and lifestyle	
80. How long was your maternity leave?	Yourself / Number of months / The child's father / Number of weeks
81. Do you have any income at the moment?	<i>No / Yes</i>
82. If yes, how many hours do you work per week	hours
83. If you are employed, have you been on sick leave since you started working? If yes, please state number of days	<i>No / Yes, due to own illness / Yes, due to child's illness / Number of days</i>
84. Is your economy so good that you could pay an unexpected bill of \$350 - a dental or repair bill for example?	<i>No / Yes / Don't know</i>
85. Have you, during the last 6 months, had problems paying your monthly bills - food rent, transport etc.?	<i>No, never / Yes, but very rarely / Yes, sometimes / Yes, often</i>
86. How often, at present, do you take part in physical activity that makes you sweat and breath heavily? (<i>fill in for both work and leisure</i>)	<i>Leisure / At work</i> 1. Never /2. Less than once a week /3. Once a week /4. Twice a week /5. 3-4 times a week /6. 5 times or more a week

87. How often do you usually exercise at the present time? (<i>fill out each line</i>)	<i>Never / 1-3 times a month / Once a week / Twice a week / 3 times or more a week</i> Activity /1. Walking/2. Brisk walking/3. Running/Jogging/orienteering/ 4. Bicycling/5. Training studio/weight training /6. Gymnastics/Aerobics/dance without jumps and running/ 7. Aerobics/gymnastics with running and jumping/ 8. Folk dancing/swing/ Rock/disco dancing/ 9. Skiing/10. Team sports/11. Swimming/12. Riding/13. Other
88. What are the smoking habits in your home at the moment?	<i>Yourself / Your live-in boyfriend/husband</i> 1. Non-smoker /2. Smoke occasionally /3 Smoke daily /If daily no. of cigarettes a day
89. How often do you drink alcohol now?	<i>Approx. 6-7 times a week / 4-5 times a week / 2-3 times a week / Once a week /1-3 times a month / Less than once a month / Never</i>

<p>In order to compare the different types of alcohol, we ask about what we call alcohol units (= 1.5 cl. pure alcohol). 1 alcohol unit means:</p> <p>1 beer glass of beer = 1 alcohol unit</p> <p>1 wine glass red or white wine = 1 alcohol unit</p> <p>1 wine glass sherry or other fortified wine = 1 alcohol unit</p> <p>1 snaps glass spirits or liqueur = 1 alcohol unit</p> <p>1 bottle/can energy drink or cider = 1 alcohol unit</p>	
<p>90. How many units of alcohol do you normally consume when you drink? (both during the week and in weekends) (<i>see above explanation of alcohol units</i>)</p>	<p><i>In the weekend / During the week</i></p> <p>10 or more / 7-9 / 5-6 / 3-4 / 1-2 / Less than 1</p>

You and your feelings	
<p>91. If you have partner/husband, how much do you agree with these statements about your relationship with your partner (<i>fill in each line</i>)</p>	<p><i>Agree completely/ Agree/ Agree somewhat/ Disagree somewhat/ Disagree/ Disagree totally</i></p> <p>1. There is a close relationship between my partner and me /2. My partner and I have problems in our relationship /3. I am very happy in my relationship with my partner /4. My partner is generally very understanding /5. I often think about ending our relationship /6. I am satisfied with my relationship with my partner /7. We often disagree on important decisions /8. I have been lucky in my choice of a partner /9. We agree on how to bring up children /10. I think my partner is satisfied with our relationship</p>
<p>92. Is there anybody apart from your husband/partner that you could consult if you find yourself in a difficult situation?</p>	<p><i>No / Yes, 1-2 persons / Yes, more than 2 persons</i></p>
<p>93. How often do you meet or talk on the telephone to your family (apart from your household) or close friends?</p>	<p><i>Once a month or less / 2-8 times a month / More than twice a week</i></p>
<p>94. Are you often feeling lonely?</p>	<p><i>Almost never/ seldom / now and then / usually/ nearly always</i></p>
<p>95. How well do these statements fit for you? (<i>Fill in each line</i>)</p>	<p><i>Not right / Partly right / Almost right / Completely right</i></p> <p>1. I can always solve a problem if I work hard enough /2. If somebody tries to counteract me, I find a way to achieve what I want /3. I am certain that I can handle unexpected situations /4. I remain calm when facing difficulties,</p>

	because I trust my ability to manage /5. If at a loss, I usually find my way out
96. How often do you experience any of the following in your everyday life? <i>(Fill in each line)</i>	<i>Seldom/never / Quite seldom / Sometimes / Often / Very often</i> 1. Feel pleased about something /2. Feel happy /3. Feel in high spirits, as if everything goes your way /4. Feel like screaming at somebody or hit out /5. Feel angry, irritated or annoyed /6. Feel furious with somebody
97. How do you feel about yourself? <i>(Fill in each line)</i>	<i>Agree totally / Agree / Disagree / Disagree totally</i> 1. I have a positive attitude to myself /2. I feel useless at times /3. I do not feel as if I have much to be proud of /4. I feel that I am as good as anyone else
98. Have you been bothered by any of the following during the last two weeks?	<i>Not bothered/ A little bothered/ Quite bothered/ Very bothered</i> 1. Frightened or anxious /2. Nervous, inner turmoil /3. Feeling of hopelessness with regard to the future /4. Depressed, sad /5. Frequently worried or uneasy /6. Feeling of hardship /7. Feeling tense or stressed /8. Sudden fear without a reason
99. Have you experienced any of the following during the last year (since the last questionnaire)? If yes, how painful of difficult did it feel? <i>(Fill in each line)</i>	<i>No / Yes / If yes / Not too serious / Painful/difficult / Very painful/difficult</i> 1. Have you had problems at work or where you study? /2. Have you had economic problems? /3. Have you been divorced, separated or ended the relationship with your partner? /4. Have you had any problems or conflicts with your family, friends or neighbors? /5. Have you had serious worries that something is wrong with your child /6. Have you been seriously ill or injured? /7. Have any of those closest to you been seriously ill or injured? /8. Have you been involved in a serious traffic accident, house fire or robbery? /9. Have you lost someone close to you? /10. Have you been forced to do sexual actions? 11. Other: _____
100. How would you evaluate your life quality?	<i>Very bad / Bad / Neither good nor bad / Good / Excellent</i>
101. How satisfied are you about your health?	<i>Very unsatisfied / Unsatisfied / Neither satisfied nor unsatisfied / Satisfied / Very satisfied</i>
102. The following questions ask about to what degree you have experienced certain situations during the last two weeks. <i>(Fill in each line)</i>	<i>Not at all / A little / To some degree / Quite much / Very much</i> 1. To what degree do you feel that pain obstruct your actions? /2. To what degree do you need medical treatment in order to function in everyday life? /3. How much do you enjoy life? /4. To what degree do you feel that life is meaningful? /5. How well can you concentrate? /6. How secure do you

	usually feel? /7. How healthy are your physical surroundings?
103. The following questions ask how completely you felt or were able to do certain tasks during the last two weeks. <i>(Fill in each line)</i>	<i>Not at all / A little / To some degree / To a large degree / Totally</i> 1. Have you got enough energy for your daily routines? /2. Can you accept the way you look? /3. Have you got enough money to meet your demands? /4. How easily available is everyday information? /5. To what degree are you able to take part in leisure activities?
104. How easily can you get where you want?	<i>With great difficulty / With difficulty / Neither difficult nor easy / Easily / Very easily</i>
105. The following questions ask how happy or satisfied you have felt in certain aspects of life during the last two weeks. <i>(Fill in each line)</i>	<i>Very unsatisfied / Unsatisfied / Neither satisfied nor unsatisfied / Satisfied / Very satisfied</i> 1. How satisfied are you about your sleep? /2. How satisfied are you about your ability to perform everyday tasks? /3. How satisfied are you about your capacity for work? /4. How satisfied are you about yourself? /5. How satisfied are you about your relationship with other people? /6. How satisfied are you about your sexual life? /7. How satisfied are you about the support you get from your friends? /8. How satisfied are you about your living conditions? /9. How satisfied are you about the availability of medical services? /10. How satisfied are you about the means of transportation available?
106. How often, during the last two weeks, have you experienced negative feelings, for instance been sorrowful, afraid or depressed?	<i>Never / Seldom / Often / Very often / Always</i>